(For Office Use Only)

Enrollment Site: _____ Local Coordinating Contractor _____

Women's Health Check Enrollment Form (page 2)
Program Consent and Information Release

IDAHO DEPARTMENT OF HEALTH & WELFARE

Women's Health Check involves a cooperative effort between clinics, doctors, mammography facilities, laboratories, the Idaho Department of Health & Welfare, and the Centers for Disease Control and Prevention (CDC). The purpose of this program is to encourage screening for breast and cervical cancer for women who are US Citizens or eligible non-citizens with low income who have no other way to pay for screening tests (no insurance coverage for these tests, no Medicare or Medicaid). The purpose of screening is to detect cancer in its earliest stage so that it can be treated or prevented. Screening for breast cancer involves a breast examination and a mammogram. Screening for cervical cancer involves a pelvic examination and a Pap test. If needed, most diagnostic tests will be available at no cost to you. Should you need treatment for cancer, you may qualify for treatment through the BCC Medicaid Program.

Authorization to Release Protected Health Information:

- ☐ I have read and understand the program description (above) of the Idaho Women's Health Check Program (WHC), understand that I am eligible for the program, and hereby consent to receive the health services as indicated above.
- ☐ By agreeing to take part in this program, I give permission to any and all of my doctors, clinics, Mammography facilities, and/or hospitals to provide all information concerning my Pap tests, breast exams, mammograms and any related diagnostic and treatment procedures to the WHC program. Case managers employed by the program may contact me for purpose of gathering information to help me access important tests and exams for adequate follow-up of abnormal test results.
- ☐ I understand that any information I give to WHC and participating providers is confidential. This means that WHC will not disclose or share my information, except for the minimum necessary to administer the Program described above. Reports, which result from this Program, will not use my name or any other identifying information.
- ☐ By signing this form, I am stating that I agree to, and understand, the terms of the program described above. I am also stating that the information I provided on the Enrollment Form is true. I understand that my participation in this Program is voluntary, and that I can drop out of the Program at any time.
- ☐ I understand that if I should be diagnosed with cancer or pre-cancerous conditions I may qualify for treatment through the BCC Medicaid program, and agree to release my information to Medicaid to determine if I am eligible for treatment.

- ☐ I have been offered the opportunity to read the Idaho Department of Health and Welfare's Notice of Privacy Practices (also available at www.healthandwelfare.idaho.gov).
- ☐ I would like Women's Health Check to send me a copy of the Idaho Department of Health and Welfare's Notice of Privacy Practices.

_____	_____	_____/_____/_____
Signature	Print Name	Date